PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): Sponsor's Social Security Number

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patient's Name

3. PATIENT'S BIRTH DATE MM DD YY: 01/01/1929 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Sponsor's Name

5. PATIENT'S ADDRESS (No., Street): Patient's Address

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☒ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): Sponsor's Address

CITY | STATE

8. PATIENT STATUS: Single ☐ Married ☒ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): If Known

10. IS PATIENT'S CONDITION RELATED TO: Not Applicable

11. INSURED'S POLICY GROUP OR FECA NUMBER: Sponsor's Social Security Number

a. OTHER INSURED'S POLICY OR GROUP NUMBER: If Known

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY: 05/05/1929 SEX M ☒ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: Not Applicable

c. EMPLOYER'S NAME OR SCHOOL NAME: Not Applicable

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME: TRICARE

d. INSURANCE PLAN NAME OR PROGRAM NAME: Not Applicable

10d. RESERVED FOR LOCAL USE: Not Applicable

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Patient's Signature DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Patient's Signature

14. DATE OF CURRENT: MM DD YY Not applicable ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: Not applicable

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM Not applicable TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Treating Provider's Name

17a. I.D. NUMBER OF REFERRING PHYSICIAN: Provider's ID Number

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM Not applicable TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES: Not applicable

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. Diagnosis 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.: Not Applicable

23. PRIOR AUTHORIZATION NUMBER: Not Applicable

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 Dates of Service		N/A	N/A	See	Itemized Bill	N/A	Charges	N/A	N/A	N/A	N/A	N/A not applicable
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: Not Applicable

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE $ total Charge

29. AMOUNT PAID $ not applicable

30. BALANCE DUE $ Balance

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Provider's Signature
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Place of Care Name and Address

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Same as Block #32

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Attachment 1

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123-45-6789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe Betty L

3. PATIENT'S BIRTH DATE MM DD YY: 01/01/1919 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe John L

5. PATIENT'S ADDRESS (No., Street): 111 HQBN

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☒ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 111 HQBN

CITY: APO STATE: AP

8. PATIENT STATUS: Single ☐ Married ☒ Other ☐

CITY: APO STATE: AP

ZIP CODE: 99999 TELEPHONE (Include Area Code): (555)555-5555

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: 99999 TELEPHONE (INCLUDE AREA CODE): (555)555-5555

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 123-45-6789

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY: 05/05/1929 SEX: M ☒ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME: TRICARE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Betty L Doe DATE: 1/5/05

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Betty Doe

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dr. S Smith

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 111-11-1111

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. Pneumonia
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01/05/2005	01/05/2005			See	Itemized Bill		480.00					
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 111-11-1111 ☐ ☒

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 480.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 480.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: Dr. S Smith DATE: 1/5/05

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Medical Center Five
111 5th Street
Cebu City 11115

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Medical Center Five
111 5th Street
Cebu City 11115

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Attachment 2